IMPACT PLUS INDIVIDUAL TREATMENT PLAN (TFC & TGR only)

Meeting Date _____Region_____

DEMOGRAPHICS

Recipient Name: _____
DOB: _____
Medicaid ID Number: _____

Current Placement: _____

Agency Contact Person: _____
Agency: _____
Agency Phone: _____
Agency Fax: _____

STRENGTHS ASSESSMENT

CHILD STRENGTHS

Strengths:_____

_____

FAMILY STRENGTHS

Strengths:_____

_____

PLAN FOR FAMILY INVOLVEMENT

_____

_____

NATURAL SUPPORTS

Supports:_____

_____

DSM IV ASSESSMENT

Axis I:_____

Axis II:_____

Axis III:_____

Axis IV:___Mild___Moderate___Severe
___Support Group___Social Environment___Educational Problems___Occupational Problems ___Housing Problems___Economic Problems
___Health Care Service Problems ___Legal/Criminal Problems

Axis V: GAF___current___past GARF___(when available)

CLINICAL INFORMATION

Current symptoms/behaviors related to a Mental Health diagnosis that are causing significant impairment in functioning that place the child at risk of institutionalization:

_____

_____

_____

Recipient's Name_____DOB_____

DISCHARGE PLAN

Projected discharge date:_____

Behavioral indicators child/family is ready for discharge:_____
_____
_____

Goal for level of care/support for child/family at discharge:_____
_____

CRISIS ACTION PLAN

Symptoms / behaviors that indicate a crisis:_____
_____

Strategies to Manage Crisis: Strategies should progress through a continuum of care from natural support to inpatient services if applicable.

Strategy One:_____

Strategy Two:_____

Strategy Three:_____

Strategy Four:_____

Strategy Five:_____

Strategy Six:_____

TEAM MEMBERS' SIGNATURES

I, the Parent/Legal Guardian/Caregiver of the Child or Youth stated on this care plan agree with this care plan and have been made aware of my right to Freedom of Choice among sub-providers authorized to provide each service on this service plan.

_____ _____ _____ _____
Parent/Legal guardian/Caregiver (if child is under 18) Date Child or Youth (Not Required) Date

As a team member, I understand that I am to keep all information shared about this child confidential.

_____ _____ _____
Behavioral Health Professional (Required) Agency Date

_____ _____ _____
Agency Contact Person (Required) Agency Date

_____ _____ _____
Other Agency Date

_____ _____ _____
Other Agency Date